LETTER TO THE EDITOR

As a practicing psychiatrist for 40 years (if residency training is included) with experience in both end-of-life care and the assessment of suicide behaviors, I have always objected to the use of the term “assisted suicide” when applied to terminally ill patients. A physician’s efforts to help terminally ill people bring their lives to a dignified conclusion should be referred to as “assisted dying.” This is not a minor semantic point. As both Drs. Ronald Pies and Cynthia Geppert have pointed out, there are 4 European countries that allow physicians to assist people who are not terminally ill in ending their lives (“Physician-Assisted Dying for Adolescents With Intractable Mental Illness?” Psychiatric Times, May 2016, pp 1,27-31).

Canada recently passed a yet-to-be-implemented federal law that will also allow this practice. It appears from the experience in Europe that all cases of non-terminally ill people who pursue this assisted dying path have a major psychiatric disorder from which they are seeking relief. Unlike efforts to help terminally ill people, this activity when applied to non-terminally ill people can legitimately be called “assisted suicide” and should be strongly condemned by all physicians and the health care establishment at large. There is a clear reason to distinguish the terms “assisted dying” and “assisted suicide.” Language and terminology matter. -Richard Krugley, MD

My point is that there is a clear reason to distinguish the terms “assisted dying” and “assisted suicide.” Language and terminology matter. The ethical, moral, and public policy implications of this distinction should make this a high priority for the Psychiatric Times editorial staff.

Richard Krugley, MD, DABPN, LFAPA
Interim Chair, Department of Psychiatry
St. John’s Episcopal Hospital
Far Rockaway, NY

Drs. Pies and Geppert Reply

We thank Dr. Krugley for his thoughtful comments on physician-assisted suicide (PAS) and “assisted dying.” Each of these designations expresses a value judgment about the nature and intentionality of the practice. Thus, those who believe PAS is ethically justifiable tend to use the term “assisted dying” to place this intervention squarely in the mainstream of end-of-life care. In contrast, those who question the ethical justifiability of providing patients with lethal prescriptions favor the use of “assisted suicide” as more truthfully naming the action.1

As Dr. Krugley rightly notes, our use of language is a critical issue when discussing end-of-life options. Whether our terminology is emotionally “loaded,” pejorative, or approving has important implications for how we conceptualize the ethical issues at stake. Indeed, euphemisms have been utilized in everything from advertising to fascism to desensitize the moral sense of the public. Some of these linguistic considerations are discussed elsewhere,1 and the general ethical issues involved in the PAS debate are nicely outlined in a paper by Starks and colleagues.2

We fully agree with Dr. Krugley that there are both medical and ethical reasons why “a physician’s efforts to help terminally ill people bring their lives to a dignified conclusion” differ radically from similar efforts in patients who do not have a terminal illness, whether physical or mental.3,4 Indeed, we further agree with Dr. Krugley that, “Unlike efforts to help terminally ill people, this [assistance] when applied to non-terminally ill people can legitimately be called ‘assisted suicide’ and should be strongly condemned by all physicians and the health care establishment at large.”

The importance of distinguishing medically validated terminal illness (such as end-stage pancreatic...
cancer) from non-terminal illness (such as schizophrenia or major depression) was recently affirmed by the Board of Trustees of the American Psychiatric Association (APA), whose statement reads: The American Psychiatric Association, in concert with the American Medical Association’s position on Medical Euthanasia, holds that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death.\(^5\)

Contrary to some misinterpretations of this statement, the APA was not tacitly condoning or endorsing interventions “for the purpose of causing death” in cases of terminal illness [personal communications, Mark S. Komrad, MD, Annette Hanson MD, 12/16/16]. We respect Dr. Krugley’s long experience with end-of-life care, and we acknowledge that both the linguistic and the ethical issues in this context are extremely complex and controversial. That said, we are troubled by the term “assisted dying” when it is applied—even in cases of terminal illness—to a physician’s prescribing a lethal medication to the patient. We believe that this goes beyond “assisting dying” as this term is understood in palliative and hospice medicine, and in the sense to which we would restrict this term, ie, to situations in which futile measures that merely prolong the dying process are discontinued.

Thus, in the case of a terminally ill patient with end-stage pancreatic cancer, we would apply the term “assisted dying” when—at the request of a mentally competent patient—the treating physician discontinues “heroic” measures such as artificial ventilation or tube feedings. In the Judaic tradition, this is known as “removing impediments” to dying—and this is clearly distinguished from deliberately ending the patient’s life or aiding the patient in doing so.\(^6\) Similarly, in Catholicism, there is no spiritual or moral obligation to endure the burden of extraordinary suffering to prolong physical life.\(^7\) It is the physician’s role to provide emotional support to patient and family during the patient’s final days—and to do everything medically possible to alleviate the dying patient’s pain and suffering. -Ronald W. Pies, MD and Cynthia Geppert, MD

We understand that the term “suicide”—as usually used in a psychiatric context—typically involves a person with a serious psychiatric disorder, such as major depression, often acting in a state of impaired judgment, and sometimes impulsively. We acknowledge that this is not the case when someone with a terminal illness, after due deliberation and consultation with health care professionals, competently requests a lethal medication from a physician. In that sense, the term “suicide” is arguably imprecise or somewhat misleading when applied to the latter situation. Nevertheless, if we use the “ordinary language” definition of “suicide,” ie, “the act or an instance of taking one’s own life voluntarily and intentionally especially by a person of years of discretion and of sound mind,”\(^8\) then the term “suicide” applies in both situations—even when a competent, terminally ill person takes a lethal medication prescribed by a physician. Thus, we would regard the term “physician-assisted suicide” as roughly appropriate, even if imperfect, in such cases. Furthermore, we hold that assisting suicide—however it is expressed in language—is against the fundamental clinical and ethical commitment of psychiatry to prevent suicide whenever possible, and to care for those who have tried or intend to take their own lives.

As ethicists, we understand that end-of-life decisions are painful, complex, and controversial, and we do not presume that there are ideal resolutions to the dilemmas doctors and patients face in such tragic circumstances. Nonetheless, we do not believe it is the physician’s role to provide lethal medications to any person—terminally ill or otherwise—with the express purpose of helping bring about the person’s death. Rather, it is the physician’s role to provide emotional support to patient and family during the patient’s final days—and to do everything medically possible to alleviate the dying patient’s pain and suffering. This includes, but is not limited to, using palliative sedation or supporting patients who voluntarily stop eating and drinking.\(^9,10\)

Ronald W. Pies, MD
Professor of Psychiatry and Lecturer on Bioethics
SUNY Upstate Medical University
Syracuse, NY
Clinical Professor of Psychiatry
Tufts University School of Medicine
Boston, MA

Cynthia Geppert, MD, MA, MPH, MSBE, DPS, FAPM
Professor of Psychiatry and Director of Ethics Education
University of New Mexico School of Medicine
Chief, Consultation Psychiatry and Ethics
Not Just a Matter of Semantics
Published on Psychiatric Times
(http://www.psychiatrictimes.com)

New Mexico VA Health Care System
Albuquerque, NM

This article was originally posted on 1/19/2017 and has since been updated.

References:

Source URL: http://www.psychiatrictimes.com/blogs/couch-crisis/not-just-matter-semantics

Links: